DIGESTIVE HEALTH CENTER

Agile Patency Capsule Record

Patient Name: _____ DOB: _____ MRN#:_____

Indication: _____

Referring Provider: _____ Ordering Provider: _____

Pre-Procedure

Yes	No	
☐	☐	Pacemaker
☐	☐	Defibrillator
☐	☐	Difficulty Swallowing
☐	☐	MRI Scheduled

☐ Pre-Capsule Preparation Followed

☐ Contraindications Reviewed

☐ Patient Consent Obtained

Procedure

Date: _____ Arrival time: _____ NPO: _____

Capsule ingested at: _____

Difficulty ingesting: ☐ Yes ☐ No

☐ Abdominal X-Ray schedule at: _____ on: _____ time: _____

☐ Order given to patient

☐ Order faxed

Nurse signature: _____ Date:_____

DIGESTIVE HEALTH CENTER
DigestiveHealthCenter.com

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